Health Services
LOS ANGELES COUNTY

August 15, 2006

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

APPROVAL OF TWO STANDARD AGREEMENT AMENDMENTS FROM THE STATE MANAGED RISK MEDICAL INSURANCE BOARD
(All Districts) (3 Votes)

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and instruct the Director of Health Services, or his designee, to execute the following Standard Agreement Amendments from the State Managed Risk Medical Insurance Board (MRMIB) to support the Community Health Plan's (CHP) Healthy Families Program (HFP): 1) Amendment No. 1 to Agreement No. 05MHF008 (Exhibit I) to increase funding by $20,756,209, from $22,612,900 to $43,369,109; and 2) Amendment No. 1 to the related State Supported Services Agreement No. 05MHF045 (Exhibit II) to increase funding by $2,609, from $5,000 to $7,609, both effective July 1, 2006 through June 30, 2008.

2. Approve and instruct the Director of Health Services, or his designee, to execute future amendments to the above Standard Agreements, or replacement agreements thereof, with MRMIB, for the period of July 1, 2006 through June 30, 2008, in amounts not less than 90% of the prior fiscal year award, following review and approval by County Counsel, Chief Administrative Office and notification to the Board within thirty days after execution.

PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTIONS:

The Department of Health Services (Department) is recommending approval of these actions to: a) ensure continued funding and provision of HFP services to eligible CHP members; and b) allow delegated authority to execute future amendments or replacement agreements with MRMIB.

FISCAL IMPACT/FINANCING:

The funding for the HFP is provided by MRMIB on a per-member per-month basis, at a capitated rate for each HFP beneficiary enrolled in CHP. The additional funds provided under these Amendments are the direct result of CHP's re-negotiation of rates with MRMIB. The increase in rates will assist the CHP to address the rising costs of health care by adjusting the reimbursement rates to DHS facilities and CHP contracted providers. The revised rates will be kept confidential in accordance with Section 1457 of the California Health and Safety Code, and will be shared with each Board Office, the CAO, and County Counsel.

There is no net County cost associated with this action.

Bruce A. Chernof, MD
Director and Chief Medical Officer

John R. Cochran III
Chief Deputy Director

William Loos, MD
Acting Senior Medical Officer

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Los Angeles, CA 90012

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FACTS AND PROVISIONS/LEGAL REQUIREMENTS:

The CHP, a full-service Knox-Keene licensed and federally qualified Health Maintenance Organization (HMO) is the County's publicly operated HMO administered by the Department's Office of Managed Care. CHP provider services are funded by L.A. Care Health Plan for Medi-Cal beneficiaries, the County health plan for County temporary employees, MRMIB for HFP subscribers, and the Personal Assistance Services Council for eligible In-Home Supportive Services workers.

HFP - MRMIB Amendment

On May 19, 1998, the Board approved the initial Standard Agreement (SA) No. 97MHF063 with MRMIB to fund health services to eligible HFP children enrolled under CHP, effective May 1, 1998 through June 30, 2000.

On June 30, 2000, the Board approved SA No. 00MHF007 with MRMIB for the continued provision of health care services provided by the HFP, effective July 1, 2000 through June 30, 2003. Subsequently, the Board approved four amendments to this SA that provided additional funds and extended the term through June 30, 2005. On June 15, 2004, the Board authorized delegated authority to accept and sign future amendments to SA No. 00MHF007, and replacement agreements thereof, with MRMIB for the period of July 1, 2004 through June 30, 2008, in amounts not less that 90% of Fiscal Year (FY) 2004-05 base award, following review and approval by County Counsel and notification to the Board.

On July 7, 2005, the Department exercised its delegated authority and executed replacement agreement SA No. 05MHF008 in the amount of $22,612,900, for the continued provision of health care services provided by the HFP, for the period of July 1, 2005 through June 30, 2008.

Approval of the recommended Amendment No. 1 to SA No. 05MHF008 will provide additional funding for the continued provision of health care services and allow for delegated authority for future amendments and replacement agreements with MRMIB through June 30, 2008.

HFP - MRMIB State Supported Services Amendment

On December 2, 2003, the Board approved the State Supported Services Agreement to provide 100% State funding of certain HFP services for "abortions that are not the result of incest or rape, and are not necessary to save the life of the mother," pursuant to federal regulations governing the Children's Health Insurance Program. Such services were formerly funded under Agreement No. 97MHF063, which used both State and federal dollars.

On June 15, 2004 the Board authorized delegated authority to accept and sign future amendments to SA No. 03MHR018, and replacement agreements thereof, with MRMIB for the period of July 1, 2004 through June 30, 2008, in amounts not less that 90% of the FY 2004-05 base award, following review and approval by County Counsel and notification to the Board.

On July 7, 2005, the Department exercised its delegated authority and executed a replacement State Supported Services Agreement No. 05MHF045 for certain HFP services, for the period of July 1, 2005 through June 30, 2008.

Approval of the recommended Amendment No. 1 to State Supported Services Agreement No. 05MHF045 will provide additional funding for the continued provision of supported services for certain HFP services and allow for delegated authority for future amendments and replacement agreements with MRMIB through June 30, 2008.

Attachment A provides additional information.

Exhibits I and II have been approved as to form and use by County Counsel.

CONTRACTING PROCESS:

It is not appropriate to advertise Amendments with the State on the Los Angeles County Online Website.

IMPACT ON CURRENT SERVICES (OR PROJECTS):

The State/County MRMIB Agreement Amendment and related State Supported Services Agreement Amendment provide funding for the County's continued participation in the State's HFP.

When approved, this Department requires four signed copies of the Board's action.

Respectfully submitted,

Bruce A. Chernof, M.D.
Director and Chief Medical Officer

BAC:lvb
MRMIB Bltr_lvb

Attachments (3)

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Office of Managed Care

ATTACHMENT A

SUMMARY OF AMENDMENTS

1. Types of Services:

   The State/County Managed Risk Medical Insurance Board (MRMIB) funds Community Health Plan (CHP) health services to eligible individuals. These services are delivered under the CHP's provider network consisting of: 1) County facilities; 2) primary/specialty care contractors affiliating with private hospital contractors; 3) primary care contractors affiliating with County hospitals; 4) network providers; and 5) subcontracted pharmaceutical service providers under the pharmacy benefit management contractor.

2. Agency Name:

   State of California - MRMIB
   1000 G Street, Suite 450
   Sacramento, CA 95814
   Attention: Don Minnich
   Telephone: (916) 327-7978

3. Term:

   The term of Amendment No. 1 to Agreement No. 05MHF008 with MRMIB and Amendment No. 1 to the related State Supported Services Agreement No. 05MHF045 is July 1, 2006 through June 30, 2008.

4. Financial Information:

   The funding for the Healthy Families Program (HFP) is provided by MRMIB on a per-member per-month basis, at a capitated rate for each HFP beneficiary enrolled in CHP. The additional funds provided under these Amendments are the direct result of CHP's re-negotiation of rates with MRMIB. The increase in rates will assist the CHP with addressing the rising costs of health care by adjusting the reimbursement rates to DHS facilities and CHP contracted providers. The revised rates will be kept confidential in accordance with Section 1457 of the California Health and Safety Code, and will be shared with each Board Office, the Chief Administrative Office, and County Counsel.

   There is no net County cost associated with this action.

5. Geographic Area To Be Served:

   Countywide.

6. Accountable for Program Monitoring:

   Office of Managed Care.

7. Approvals:

Office of Managed Care:	Dave Beck, Acting Director
Contract Administration:	Cara O'Neill, Chief
County Counsel:	Eddie Yen, Senior Associate

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213 A (Rev 6/03)

EXHIBIT I

[X] **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** 22 **Pages**

AGREEMENT NUMBER	AMENDMENT NUMBER
05MHF008	A1
REGISTRATION NUMBER	
4280040571892.1	

1. This Agreement is entered into between the State Agency and Contractor named below:
   STATE AGENCY'S NAME
   Managed Risk Medical Insurance Board
   CONTRACTOR'S NAME
   The County of Los Angeles, dba: Community Health Plan
2. The term of this Agreement is July 1, 2005 through June 30, 2008
3. The estimated amount of this Agreement after this amendment is: $43,369,109 ($20,756,209 added)
4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   I. This Agreement is hereby amended for the purpose of adding money to the Agreement for an additional year, for specifying any geographic coverage changes to add revised performance measures, for revising the Confidential Attachment, Rates of Payment for July 1, 2006 through June 30, 2007, and to make other administrative and technical changes.

   II. This Agreement is amended as follows through the revision and incorporation of the following attachments and exhibits as if fully set forth herein:

   Attachment I - Geographic Area Grid
   Attachment III - Performance Measures
   Attachment VI - Confidential Rates of Payment.

(continued)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
The County of Los Angeles, dba: Community Health Plan

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Bruce A. Chernof, M.D., Director & Chief Medical Officer

ADDRESS
313 N. Figueroa, Los Angeles, CA 90012

STATE OF CALIFORNIA

AGENCY NAME
Managed Risk Medical Insurance Board

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Dennis Gilliam, Contracts Administrator

ADDRESS
1000 G Street, Suite 450, Sacramento, CA 95814

CALIFORNIA
Department of General Services
Use Only

☐ Exempt per:

III. Item F, Identification Cards, Provider Directory and Evidence of Coverage, in Item II of Exhibit A is amended to read as follows:

F. Identification Cards, Provider Directory, and Evidence of Coverage

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, issue or offer a Provider Directory, and issue an Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider. The contractor's Evidence of Coverage booklet, as approved by the State, is hereby incorporated by reference, as fully set forth within.

2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall provide the Identification Card, issue or offer a Provider Directory, and provide an Evidence of Coverage booklet and other materials described in Item II.F.1. to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3. a. In addition to the instances described in Items II.F.1. through II.F.2., above, the Contractor shall, by April 1 of each year, issue or offer to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and issue either an updated Evidence of Coverage booklet (or amended pages) setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to the benefits package that will go into effect at the beginning of the next benefit year.

b. In any year in which an updated Evidence of Coverage booklet (or amended pages) is not issued by April 1, the

Contractor shall issue an updated Evidence of Coverage booklet by June 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.

c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage booklet (or amended pages) and the letter describing changes in the benefit package. The letter shall be submitted to the State by March 1 for review and approval.

d. By July 1 of each year, the Contractor shall submit to the State three copies of the updated Evidence of Coverage booklet (or amended pages) and one copy of the updated Provider Directory.

4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.

5. The Contractor's Provider Directory shall indicate the language capabilities of the providers.

6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage booklet or a Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.

7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

IV. Item J, Enrollment Data, in Item II of Exhibit A is amended to read as follows:

J. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept

this information via EDI and update its enrollment system within 3 calendar days, excluding holidays. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets.

2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the failed or delayed enrollment transaction can be generated and sent to the Contractor.

3. The State shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.

4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.

5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor shall use the data files to reconcile and validate weekly activity.

6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Standard Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday. If the weekly transmission is not completed by the stated time, the State shall promptly notify the Contractor of the date and time when the transmission will be completed.

7. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being reported. If unexpected circumstances cause a delay in the

provision of the audit files, the State, through the administrative vendor's assigned plan liaison, shall notify the Contractor.

8. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by the Contractor after this 60-day period. The State shall respond to discrepancies timely submitted to the state by the Contractor.

9. The State shall transmit the files described in Items II.J.1., II.J.5., and II.J.7. to the Contractor at no charge.

10. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items II.J.5. and II.J.7. above within six months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items II.J.5. and II.J.7. above at the rate of $85 per hour or $250 per report or file, whichever cost is greater. The State shall waive the assembly and retransmission fee if the State determines that the original transmission file was corrupted or unusable.

11. With respect to Items II.J.5. and II.J.7. above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There shall be no charge for the services of the State's plan liaison.

12. Prior to commencing work requested by the Contractor under Item II.J.10., the State shall provide a cost estimate to the Contractor.

13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.

14. The State shall conduct at least one meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.

15. The Contractor agrees either to use the Program's unique Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

V Item L., Traditional and Safety Net Providers, in Item II of Exhibit A is amended to read as follows:

L. Traditional and Safety Net Providers

1. The Contractor agrees to establish, with traditional and safety net providers as described in Article 4 of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.

2. The Contractor shall, on or before April 30 of each year, report to the State on the number of subscribers who selected traditional and safety net providers as the subscriber's primary care physician in the previous year. The format for the report shall be determined by the State.

3. No later than January 15 of each year, the Contractor shall provide the State with a list of those traditional and safety net providers (as described in Article 4 of the Program regulations) that have signed contracts with the Contractor to provide services to Program subscribers.

4. The Contractor assures the State that it has signed contracts with all providers the Contractor has listed in its Traditional and Safety Net Provider Report described in Item II.L.3. above, and shall provide the State with copies of the contracts, if requested by the State.

VI. Item C, Cultural and Linguistic Services, in Item III of Exhibit A is amended to read as follows:

C. Cultural and Linguistic Services

1. Linguistic Services

a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

b. The Contractor shall provide twenty-four (24) hour access to interpreter services for all (LEP) subscribers seeking health services within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures must include ensuring compliance of any subcontracted providers with these requirements. Activities that the Contractor may undertake to assure compliance of subcontracted providers include, but are not limited to, employing competent bilingual or multilingual staff who can interpret for providers and subscribers, and using competent contracted community-based organizations for interpreter services.

c. When the need for an interpreter has been identified by the provider, or requested by a subscriber the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall avoid unreasonable delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall instruct the providers within its health maintenance organization network to record the language needs of subscribers in the medical record.

d. The Contractor agrees that subscribers shall not be required to or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall encourage the use of qualified interpreters. The Contractor agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical records of providers in the Contractor's health maintenance organization network. Activities that the Contractor may undertake to ensure compliance of providers with this paragraph include, but are not limited to, training its providers on the need to document a request or refusal of interpreter services; supplying providers and their staff with Request/Refusal forms for interpreter services ; supply providers and their staff with chart labels identifying member language needs; implementing an incentive program to reward

provider offices that affirmatively attempt to identify language needs of LEP members and record them on the medical charts; conducting reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services; and providing other technical assistance to providers.

e. The Contractor shall inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers; the right to receive subscriber materials as described in Item III.C.2. of this Exhibit; and the right to file a complaint or grievance if linguistic needs are not met.

f. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions. Activities that the Contractor may undertake to ensure the bilingual proficiency of interpreters at medical and non-medical points of contact include, but are not limited to: hiring staff who demonstrate conversational fluency as well as fluency in medical terminology; providing training that will enable staff to take, or assist with gathering, information for an accurate medical history with culturally related consent forms; providing dictionaries and glossaries for interpreters; providing provider staff with consistent interpreter training by experienced and properly trained interpreters; periodically assessing the language proficiency of the plan's identified medical and non-medical staff who have patient contact; conducting audits of provider sites to confirm ongoing language capabilities of providers and staff; and providing other technical assistance to providers.

g. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.K. of this Exhibit.

2. Translation of Written Materials

a. The Contractor agrees to translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the lesser of five percent (5%) of the Contractor's enrollment or 3,000 subscribers of the Contractor's enrollment in the Program. If the Contractor serves both Medi-Cal and Program subscribers, it is encouraged, where practicable, to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials. Activities that the Contractor may undertake to comply with this paragraph include, but are not limited to, informing LEP subscribers, during the welcome call, of the plan's language assistance services; encouraging members to call the Contractor if they need help in understanding any of the Contractor's written materials; providing an oral translation of the material in a member's preferred language or arranging for this to be done by a competent interpreter service; and making the content of the written materials available in alternative formats such as Braille, CD, and audio cassette.

b. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Activities that the

Contractor may undertake to ensure the quality of translated materials include, but are not limited to, contracting and using certified translation companies that follow a step-by-step translation process; performing back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator; having an internal team review committee that includes a medical and/or legal "professional reviewer" who reviews translated materials for cultural appropriateness; and proof-reading and editing of the document by a separate qualified translation editor/proof reader. The Contractor may use computer technology as part of the process for producing culturally and linguistically appropriate translation. Guidelines for developing and producing culturally and linguistically appropriate translations and definitions for the terms used are included in Attachment IV, Translated Process Flowchart.

c. By September 30 of each year, the Contractor shall submit to the State one copy of only those materials that, pursuant to Item II.E., are routinely provided to new subscribers for each language in which the materials are translated.

3. Cultural and Linguistic Group Needs Assessment

a. By June 30, 2007, the Contractor agrees to conduct and submit to the State a Cultural and Linguistic Needs Assessment to promote the provision and utilization of appropriate services for its diverse enrollee population. The Needs Assessment report shall include findings from the assessment described in Item III.C.3.b. below and a plan outlining the proposed services to be improved or implemented as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing racial, ethnic, and language disparities.

b. The Cultural and Linguistic Needs Assessment shall examine the demographic profile of the Contractor's Program enrollees by ethnicity and language to assess their linguistic and cultural needs. The assessment shall be conducted in accordance with guidelines issued by the State and shall examine the language preference of the Program enrollees and other data, including, but not limited to, the health risks, beliefs, and practices of the Contractor's enrollees. The Contractor may conduct the Needs Assessment individually or collaboratively with other plans participating in the Program.

c. The Contractor shall assess the internal systems it has in place to address the cultural and linguistic needs of its Program enrollment

population, including, but not limited to, assessing the Contractor's capacity to provide linguistically appropriate services. The Contractor shall review internal data including complaints and grievances, results from member surveys, diversity and language ability of staff as reflective of the enrollee population, internal policies and procedures, education and training of staff and providers regarding cultural and linguistic competency issues, and, to the extent feasible, utilization and outcome data analyzed by race, ethnicity and primary language. This information shall be examined in relation to and compared with external data for benchmarking and trends.

d. The Contractor agrees to provide an opportunity for representatives of subscribers enrolled in the Program to provide input on the Cultural and Linguistic Needs Assessment. The Contractor may use an existing member advisory committee or community advisory committee for the purposes of providing an opportunity for Program subscribers to provide input. The Contractor shall ensure that the committee used to obtain input from subscribers is representative of subscribers in the program and includes representatives from hard-to-reach populations. The Contractor shall also ensure that the committee holds regular meetings and is provided with adequate resources to support committee activities and support staff.

4. Operationalizing Cultural and Linguistic Competency

a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

b. Activities that the Contractor may undertake in developing its internal systems to meet the cultural and linguistic needs of the Contractor's subscribers include: incorporating cultural competency in the Contractor's mission; establishing and maintaining a process to evaluate and determine the need for special initiatives related to cultural competency; developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community; assessing the cultural competence of plan providers on a regular basis; establishing a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines; providing

an array of communication tools to distribute information to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues); participating with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure that the Contractor maintains current information and an outside perspective in its policies; maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data; and evaluating the effectiveness of strategies and programs in improving the health status of cultural-defined populations.

c. The Contractor shall report, on or before December 10 of each year, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient applicants and subscribers in the Program. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The Contractor shall also report its efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers. The report shall also address activities undertaken by the Contractor to develop internal systems, as described in Item III.C.4.b of this Exhibit. The Contractor shall also report on the status of the Contractor's cultural and linguistic activities developed from the Needs Assessment. The format for this report shall be determined by the State.

VII. Item B., Measuring Consumer Satisfaction, in Item V of Exhibit A is amended to read as follows:

B. Measuring Consumer Satisfaction

1. The Contractor understands that the State intends to conduct an annual consumer satisfaction survey of Program participants using the most recent release of NCQA's version of the Consumer Assessment of Health Plans Survey (CAHPS®). The Contractor further understands that the State intends to conduct an adolescent

survey using the Young Adult Health Care Survey (YAHCS), as released by the Child and Adolescent Health Measures Initiative.

2. The Contractor understands that the State will conduct annual CAHPS® and YAHCS surveys, if funding is made available to the State for this purpose, using the services of a vendor selected by the State, hereafter referred to as the CAHPS® Vendor, to collect and analyze CAHPS® and YAHCS data.

3. The Contractor understands that the State intends to release the CAHPS® and YAHCS data to applicants, subscribers and other interested parties. The Contractor understands that the final decision regarding the release of information collected from the CAHPS® and YAHCS surveys shall be made by the State.

4. The State agrees to convene an open Work Group comprised of health plans, State staff, representatives of the State's Quality Improvement Work Group, and the staff of the CAHPS® Vendor to review the survey process and discuss the format and content of any data to be publicly released. The Work Group shall meet periodically during the term of this Agreement in locations throughout the State.

5. If funding is made available, the State shall pay the CAHPS® Vendor on behalf of the Contractor a survey benefit amount, to be determined by the State based upon plan enrollment and survey milestones, which determine the number of families to be surveyed.

6. The Contractor agrees to provide the State with a camera-ready and electronic copy of the Contractor's logo, a signature of a high level Contractor official and sample pieces of the Contractor's stationary and envelopes. The State assures the Contractor that the items listed in this section shall only be used in the conduct of the CAHPS® and YAHCS Surveys.

VIII. Item A, Minimum Loss Ratio in Item II. Fiscal Control Provisions, of Exhibit B is amended to read as follows:

A. <u>Minimum Loss Ratio</u>

1. The Contractor agrees that administrative costs shall be reasonable. The Contractor agrees that, once the Contractor's plan has a minimum of 1,000 enrolled subscribers per month for six or more months of a benefit year, the minimum loss ratio for services provided to all subscribers pursuant to this Agreement shall be 88%. For reporting purposes, the Contractor's loss ratio shall be

calculated in aggregate for all subscribers, using the following formula:

a/b

Where "a" is :Total covered benefit and service costs of Contractor including incurred but not reported claim completion costs minus subscriber co-payment requirements and minus amounts recovered pursuant to Exhibit A, Items IV.I, IV.J. and IV.K. of this Agreement, and

where "b" is : Total premiums received by the Contractor.

2. The Contractor shall report the previous benefit year's loss ratio by January 1 of each year.

3. The Contractor understands that the State may make the results of the loss ratio report listed in Item 2. above available to the public.

4. As part of evaluating the quality of the Contractor's operations, the State has established a goal to ensure one evaluation of the Contractor's reported loss ratio is completed on behalf of the Contractor during the three year term of this Agreement. The evaluation will be done in accordance with standards and procedures for audits, reviews, examinations and evaluations set forth in Exhibit D., Item II.D. of this Agreement. The State will notify the Contractor if the Contractor will be scheduled for an evaluation during the contract. The State will work with the Contractor regarding scheduling evaluation dates. The State will contract on behalf of the Contractor for the performance of the evaluation. The evaluations will be performed by the California Department of Managed Health Care or a qualified entity to be selected by the State. The State will pay the Department of Managed Health Care or selected qualified entity on behalf of the Contractor for the cost of the loss ratio evaluation.

IX. Item B, Payment Limitation in Item II. Fiscal Control Provisions, of Exhibit B is amended to read as follows:

B. Payment Limitation

1. Only subscribers for whom a premium is paid by the State to the Contractor are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the subscriber is enrolled.

2. The Contractor agrees to reconcile, on at least a monthly basis, eligibility data provided by the State with the Contractor's data on persons for whom claims, capitation payments, and other payments related to services and benefits were made in the Program. The Contractor shall make any necessary adjustments indicated by the reconciliation to ensure compliance with Item II.B.1. The Contractor shall maintain records of these reconciliations in accordance with Exhibit D, Item II.C. of this Agreement. The Contractor shall ensure that only the costs of services and benefits covered in the Program are included in the numerator of the loss ratio calculation set forth in Item II.A.

3. The State shall not be liable for any reconciliation discrepancies reported by the Contractor more than sixty (60) days from the date the monthly audit file is provided to the Contractor, pursuant to Exhibit A, Item II.J.8.

X. Item C., Termination for Insolvency, in Item I of Exhibit D is amended to read as follows:

C. Termination for Insolvency

Contractor shall notify the State immediately in writing in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudged bankrupt, or a receiver is appointed and qualifies. In the event of any of the foregoing events, or if the State determines, based on reliable information, that there is a substantial probability that Contractor will be financially unable to continue performance under this Agreement, the State may terminate this Agreement and all further rights and obligations immediately by giving five (5) days' notice in writing.

XI. The effective date of this amendment is July 1, 2006.

XII. All other terms and conditions of this Agreement shall remain the same.

GEOGRAPHIC AREA GRID
July 1, 2006 - June 30, 2007

Region	COUNTIES	Licensed Service Area
3	Alameda	
1	Alpine	
1	Amador	
1	Butte	
1	Calaveras	
1	Colusa	
3	Contra Costa	
1	Del Norte	
1	El Dorado	
2	Fresno	
1	Glenn	
1	Humboldt	
2	Imperial	
1	Inyo	
2	Kern	
1	Kings	
1	Lake	
1	Lassen	
5	Los Angeles	X
2	Madera	
3	Marin	
2	Mariposa	
1	Mendocino	
2	Merced	
1	Modoc	
1	Mono	
1	Monterey	
2	Napa	
1	Nevada	
4	Orange	
1	Placer	
1	Plumas	
6	Riverside	
2	Sacramento	
1	San Benito	
6	San Bernardino	
6	San Diego	
3	San Francisco	

X or X* Existing full county coverage, no change in new benefit year; X*=except Catalina Island in L.A. Co.

X or X* Changing to full county coverage in new benefit year; X*=except Catalina Island in L.A. Co.

~~X~~ Dropping full county coverage in new benefit year

P Existing partial county coverage, no change in ZIP codes

P+ or P- Existing partial county coverage, adding and/or deleting zip codes in new benefit year

P Changing to partial county coverage in new benefit year

~~P~~ Dropping partial county coverage in new benefit year

Region	COUNTIES	Licensed Service Area
2	San Joaquin	
2	San Luis Obispo	
3	San Mateo	
4	Santa Barbara	
3	Santa Clara	
2	Santa Cruz	
1	Shasta	
1	Sierra	
1	Siskiyou	
2	Solano	
2	Sonoma	
2	Stanislaus	
1	Sutter	
1	Tehama	
1	Trinity	
1	Tulare	
1	Tuolumne	
4	Ventura	
1	Yolo	
1	Yuba	

X or X* Existing full county coverage, no change in new benefit year; X*=except Catalina Island in L.A. Co.

X or X* Changing to full county coverage in new benefit year; X*=except Catalina Island in L.A. Co.

~~X~~ Dropping full county coverage in new benefit year

P Existing partial county coverage, no change in ZIP codes

P+ or P- Existing partial county coverage, adding and/or deleting zip codes in new benefit year

P Changing to partial county coverage in new benefit year

~~P~~ Dropping partial county coverage in new benefit year

ATTACHMENT III
SCHEDULE OF PERFORMANCE MEASURES
Childhood Indicators - Ages 12 Months Through 18 Years

Note This schedule outlines the performance measures to be reported by health plans during the term of this contract. The description of HEDIS® measures contained in this schedule of performance measures is not meant to be a comprehensive description of required HEDIS® measures. Plans are expected to have the most current HEDIS® information and to follow the specifications for the following measures in that document. Please note that MRMIB no longer requires the 120-day Initial Health Assessment measure.

FOR THE 2006-07 CONTRACT PERIOD

1) CHILDHOOD IMMUNIZATION STATUS (HEDIS® Measure)

The percentage of HFP enrolled children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had not more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations:

- Four DTP or DTaP vaccinations by the second birthday with at least one diphtheria and one tetanus falling on or between the child's first and second birthdays.
- Three polio (IPV or OPV) vaccinations by the second birthday
- One MMR between the first and second birthdays
- Three H influenza type B vaccinations with different dates of service by the child's second birthday and with at least one of them falling on or between the first and second birthdays
- Three hepatitis B vaccinations by the second birthday (with one of them falling between the six month and the second birthday)
- At least one chicken pox vaccination (VZV), with a date of service falling on or between the child's first and second birthdays
- A combined rate including children who have received all of the immunizations above.

2) CHILDREN'S ACCESS TO PRIMARY CARE PROVIDERS (HEDIS® Measure)

The percentage of children who have had at least one visit to a pediatrician, family physician, and other health care provider during the reporting year. Four separate cohorts are reported:

- Percentage of children age 12 through 24 months who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.

- Percentage of children age 25 months through 6 years who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.
- Percentage of children age 7 through 11 years who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.
- Percentage of adolescents 12-18 years of age who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.

3) *WELL CHILD VISIT IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS* (HEDIS® Measure)

The percentage of HFP enrolled members who were age 3 through 6 years during the reporting year who were continuously enrolled during the reporting year and who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

4) *ADOLESCENT WELL-CARE VISITS* (HEDIS® Measure)

The percentage of HFP enrolled members who were 12 through 18 years during the reporting year who were continuously enrolled during the reporting year and who had at least one comprehensive well-care visit with a primary care provider during the reporting year. Members who have had not more than one break in enrollment of up to 45 days per year should be included in this measure.

5) *ALCOHOL AND OTHER DRUG SERVICES UTILIZATION* (HEDIS® Measure)

Percentage of Members Receiving Inpatient, Intermediate, and Ambulatory Services.

The number and percentage of HFP members receiving alcohol and other drug services during the reporting year in the following categories: any alcohol and other drug services; inpatient alcohol and other drug services; intermediate alcohol and other drug services; and ambulatory alcohol and other drug services.

6) *FOLLOW-UP AFTER HOSPITALIZATION FOR SELECTED MENTAL ILLNESS* (HEDIS® Measure)

The percentage of plan members age 6 and over who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 7 and 30 days after discharge:

- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to 30 days after hospital discharge, ***and***
- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to 7 days after hospital discharge.

7) *USE OF APPROPRIATE MEDICATIONS FOR ASTHMA* (HEDIS® Measure)

The percentage of enrolled members 5 through 18 years of age during the measurement year, who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year.

8) *MENTAL HEALTH UTILIZATION)*

The number and percentage of members, by age and sex, receiving mental health services during the measurement year in four categories of service:

- any mental health services (inpatient, day/night, ambulatory)
- inpatient mental health services
- day/night mental health services
- ambulatory mental health services

9) WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE *(HEDIS® Measure*

The percentage of enrolled members who turned 15 months old during the measurement year, who received either zero, one, two, three, four, five, six or more well-child visits with a primary care practitioner during their first 15 months of life. A child should be included in only one numerator (E.g., a child receiving six well-child visits would not be included in the rate for five or fewer visits.)

FOR THE 2007-08 CONTRACT PERIOD

All measures listed above for 2006-07 and:

CHLAMYDIA SCREENING IN WOMEN (HEDIS® Measure)

The percentage of women 16-18 years of age who were identified as sexually active, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during that time and who had at least one test for Chlamydia during the measurement year.

ATTACHMENT VI
CONFIDENTIAL RATES OF PAYMENT

This attachment is confidential, and is not open until, at the earliest July 1, 2010. See Exhibit D, Item II.P. of this Agreement for the standards governing confidentiality.

I. HEALTHY FAMILIES PROGRAM RATES

- CONFIDENTIAL -

STATE OF CALIFORNIA

STANDARD AGREEMENT AMENDMENT

STD. 213 A (Rev 6/03)

EXHIBIT II

[x] CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 2 Pages

AGREEMENT NUMBER	AMENDMENT NUMBER
05MHF045	A1
REGISTRATION NUMBER	
4280040572131.1	

1. This Agreement is entered into between the State Agency and Contractor named below:
   STATE AGENCY'S NAME
   Managed Risk Medical Insurance Board
   CONTRACTOR'S NAME
   The County of Los Angeles, dba: Community Health Plan
2. The term of this Agreement is July 1, 2005 through June 30, 2008
3. The estimated amount of this Agreement after this amendment is: $7,609 ($2,609 added)
4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

   I. This Agreement is hereby amended for the purpose of adding money to the Agreement for an additional year, for specifying any geographic coverage changes, and for revising the Confidential Attachment, Rates of Payment for July 1, 2006 through June 30, 2007.

   II. This Agreement is amended as follows through the revision and incorporation of the following attachments and exhibits as if fully set forth herein:

   III. Attachment VI - Confidential Rates of Payment.

   IV. Item IV, Subsequent Amendments to Main Agreement, is added to Exhibit A to read:

   Any amendment of Agreement Number o5MHF008 will be deemed to be an amendment of the instant Agreement unless the Amendment, by its express terms, does not apply to the instant Agreement.

   V. The effective date of this amendment is July 1, 2006.

   VI. All other terms and conditions of this Agreement shall remain the same.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*
The County of Los Angeles, dba: Community Health Plan

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Bruce A. Chernof, M.D., Director & Chief Medical Officer

ADDRESS
313 N. Figueroa, Los Angeles, CA 90012

STATE OF CALIFORNIA

AGENCY NAME
Managed Risk Medical Insurance Board

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Dennis Gilliam, Contracts Administrator

ADDRESS
1000 G Street, Suite 450, Sacramento, CA 95814

CALIFORNIA
Department of General Services
Use Only

☐ Exempt per:

ATTACHMENT VI
CONFIDENTIAL RATES OF PAYMENT

This attachment is confidential, and is not open until, at the earliest July 1, 2010. See Exhibit D, Item II.P. of this Agreement for the standards governing confidentiality.

I. HEALTHY FAMILIES PROGRAM RATES

- CONFIDENTIAL -